

<i>SERFF Tracking Number:</i>	<i>SHLI-127038570</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shelter Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48004</i>
<i>Company Tracking Number:</i>	<i>03L10211</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>EZ Term Application</i>		
<i>Project Name/Number:</i>	<i>EZ Term E-App/L10211</i>		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: EZ Term Application

TOI: L04I Individual Life - Term

SERFF Tr Num: SHLI-127038570

State: Arkansas

SERFF Status: Closed-Approved-
Closed

State Tr Num: 48004

Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life

Co Tr Num: 03L10211

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Dina Krofta, Berdetta
Moore

Disposition Date: 02/23/2011

Date Submitted: 02/16/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: EZ Term E-App

Project Number: L10211

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/23/2011

State Status Changed: 02/23/2011

Deemer Date:

Created By: Berdetta Moore

Submitted By: Berdetta Moore

Corresponding Filing Tracking Number:
03L10211

Filing Description:

Form L-965 is our application for our EZ Term Life Insurance policy. This form will only be used by our sales agents for applications submitted electronically to our Home Office. Before the application is submitted, agents will give applicants a printed copy of the application for their review. Once the application data is verified, agents will obtain a wet signature from the applicant and send the signature page to our Home Office. A full, signed copy of the application will be included with the policy.

SERFF Tracking Number:	SHLI-127038570	State:	Arkansas
Filing Company:	Shelter Life Insurance Company	State Tracking Number:	48004
Company Tracking Number:	03LI0211		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name:	EZ Term Application		
Project Name/Number:	EZ Term E-App/LI0211		

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant	blmoore@shelterinsurance.com
1817 W. Broadway	573-214-4832 [Phone]
Columbia, MO 65203	573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company	CoCode: 65757	State of Domicile: Missouri
1817 W. Broadway Street	Group Code: 123	Company Type: Life and Health
Columbia, MO 65203	Group Name:	State ID Number:
(800) 743-5837 ext. [Phone]	FEIN Number: 43-0740882	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$0.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	\$50.00	02/16/2011	44768995

SERFF Tracking Number: *SHLI-127038570*

State: *Arkansas*

Filing Company: *Shelter Life Insurance Company*

State Tracking Number: *48004*

Company Tracking Number: *03L10211*

TOI: *L04I Individual Life - Term*

Sub-TOI: *L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life*

Product Name: *EZ Term Application*

Project Name/Number: *EZ Term E-App/L10211*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	02/23/2011	02/23/2011

SERFF Tracking Number: *SHLI-127038570*

State: *Arkansas*

Filing Company: *Shelter Life Insurance Company*

State Tracking Number: *48004*

Company Tracking Number: *03L10211*

TOI: *L04I Individual Life - Term*

Sub-TOI: *L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life*

Product Name: *EZ Term Application*

Project Name/Number: *EZ Term E-App/L10211*

Disposition

Disposition Date: 02/23/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>SHLI-127038570</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shelter Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48004</i>
<i>Company Tracking Number:</i>	<i>03L10211</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>EZ Term Application</i>		
<i>Project Name/Number:</i>	<i>EZ Term E-App/L10211</i>		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	EZ Term Drop Down Answers		Yes
Form	Individual Life Insurance Application		Yes

SERFF Tracking Number:	SHLI-127038570	State:	Arkansas
Filing Company:	Shelter Life Insurance Company	State Tracking Number:	48004
Company Tracking Number:	03LI0211		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name:	EZ Term Application		
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Form Schedule

Lead Form Number: L-965

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-965	Application/ Individual Life Enrollment Insurance Application Form	Initial		51.100	L-965.pdf



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

**\$50,000 LEVEL TERM
TO AGE 40**

Applicant's Family #
**APPLICATION FOR LIFE INSURANCE
EZ TERM**

Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. US Citizen or Permanent Resident: Yes ☐ No ☐ Occupation:

Policy Information

7. Payment Mode: Premium Attached:
7a. Details:
8. Primary Beneficiary:
Contingent Beneficiary:
Payor:
Owner:
Successor Owner:

Existing Insurance Information

9. Total individual life insurance in force or pending (excluding this application):
With Shelter Life: With Other Companies:
10. Do you have existing life insurance policies or contracts? Yes ☐ No ☐
If yes, please send Replacement Form L-243.29 with this application.
11. Will this application replace an existing policy or contract? Yes ☐ No ☐
If yes, please send Replacement Form L-243.33 with this application.

Underwriting and Medical Information

12. Have you, in the last 12 months, used tobacco in any form? Yes ☐ No ☐
13. Have you, in the last 3 years, been convicted of a DWI, a DUI, or any other moving violation? Yes ☐ No ☐
Details:
14. Do you participate in aviation activities or ultralight flying? Yes ☐ No ☐
15. Do you participate in hang gliding, parachute jumping, rodeo riding, underwater diving, racing of any motor
powered vehicle, or rock or mountain climbing? Yes ☐ No ☐
16. Have you, in the last 5 years, used illegal drugs or had treatment for alcohol or drug use? Yes ☐ No ☐
Details:
Physician Information:
17. Have you, in the last 5 years, had or been treated for: frequent asthma attacks or other lung disorder, Yes ☐ No ☐
diabetes, tumor, cancer, heart or blood disorder, high blood pressure, liver or kidney disease, ulcerative
colitis, Crohn's disease, multiple sclerosis, lupus, muscle disease of any kind, positive HIV test, AIDS,
seizures, depression or other mental or nervous system disorder?
Details:
Physician Information:

Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

- (a) this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;
- (b) any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;
- (c) only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;
- (d) no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and
- (e) except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
 - (1) a policy is delivered to the Owner during the lifetime of the Proposed Insured; and
 - (2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application of the completion of all medical examination requirements.

The Owner declares that the Conditional Coverage Receipt has been detached from this application and given to him or her.

☐

Yes

☐

No

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

This application is a legal document. The policy may be altered or rescinded if the questions are not answered correctly and truthfully.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Signature of Proposed Insured)

(Signature of Owner, if other than Proposed Insured)

(Date)

I hereby certify that I personally asked every question of the Owner, and Proposed Insured if other than the Owner, and accurately recorded the answers given and that I witnessed the signature(s) above.

(Signature of Writing Agent)

(Print Name of Writing Agent)

(Agent's Number)

(Agent Phone Number)

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Proposed Insured

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Print Name and Date of Birth of Spouse, If Applying

Signature of Spouse, If Applying

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or Owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER
UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount \$ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West
Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount \$ _____

by _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE
CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do
not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If
Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not
accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a
required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions
are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom
coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the
policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we
deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material
change in your answers on the application since the application date; and (3) you have paid any additional premium and/or
signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be
insured under the policy applied for prior to delivery will not exceed the lesser of: (a) \$250,000, including accidental death
benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF
THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

SERFF Tracking Number: SHLI-127038570

State: Arkansas

Filing Company: Shelter Life Insurance Company

State Tracking Number: 48004

Company Tracking Number: 03L10211

TOI: L04I Individual Life - Term

Sub-TOI: L04I.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: EZ Term Application

Project Name/Number: EZ Term E-App/L10211

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR CERTIFICATION EZ .pdf

Item Status:

Status

Date:

Satisfied - Item: Application

Comments:

Attachment:

L-965.pdf

Item Status:

Status

Date:

Satisfied - Item: EZ Term Drop Down Answers

Comments:

Attachment:

Drop Downs - EZ Term.pdf



SHELTER INSURANCE COMPANIES

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

I, Dina C. Krofta, FSA, MAAA, herby certify that we have reviewed our processes regarding Ark. Code Ann. 23-79-138, Bulletin 6-87 and Bulletin 11-88 and found them to be in compliance. We have also reviewed our procedures and are in compliance with Regulation 49 and Regulation 19§10B.

<u>Form No.</u>	<u>Name</u>	<u>Score</u>
L-965	EZ Term Application	51.1

Signed _____
Dina C. Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company



SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

**\$50,000 LEVEL TERM
TO AGE 40**

Applicant's Family #
**APPLICATION FOR LIFE INSURANCE
EZ TERM**

Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. US Citizen or Permanent Resident: Yes ☐ No ☐ Occupation:

Policy Information

7. Payment Mode: Premium Attached:
7a. Details:
8. Primary Beneficiary:
Contingent Beneficiary:
Payor:
Owner:
Successor Owner:

Existing Insurance Information

9. Total individual life insurance in force or pending (excluding this application):
With Shelter Life: With Other Companies:
10. Do you have existing life insurance policies or contracts? Yes ☐ No ☐
If yes, please send Replacement Form L-243.29 with this application.
11. Will this application replace an existing policy or contract? Yes ☐ No ☐
If yes, please send Replacement Form L-243.33 with this application.

Underwriting and Medical Information

12. Have you, in the last 12 months, used tobacco in any form? Yes ☐ No ☐
13. Have you, in the last 3 years, been convicted of a DWI, a DUI, or any other moving violation? Yes ☐ No ☐
Details:
14. Do you participate in aviation activities or ultralight flying? Yes ☐ No ☐
15. Do you participate in hang gliding, parachute jumping, rodeo riding, underwater diving, racing of any motor
powered vehicle, or rock or mountain climbing? Yes ☐ No ☐
16. Have you, in the last 5 years, used illegal drugs or had treatment for alcohol or drug use? Yes ☐ No ☐
Details:
Physician Information:
17. Have you, in the last 5 years, had or been treated for: frequent asthma attacks or other lung disorder, Yes ☐ No ☐
diabetes, tumor, cancer, heart or blood disorder, high blood pressure, liver or kidney disease, ulcerative
colitis, Crohn's disease, multiple sclerosis, lupus, muscle disease of any kind, positive HIV test, AIDS,
seizures, depression or other mental or nervous system disorder?
Details:
Physician Information:

Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

- (a) this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;
- (b) any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;
- (c) only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;
- (d) no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and
- (e) except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
 - (1) a policy is delivered to the Owner during the lifetime of the Proposed Insured; and
 - (2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application of the completion of all medical examination requirements.

The Owner declares that the Conditional Coverage Receipt has been detached from this application and given to him or her.

☐

Yes

☐

No

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

This application is a legal document. The policy may be altered or rescinded if the questions are not answered correctly and truthfully.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Signature of Proposed Insured)

(Signature of Owner, if other than Proposed Insured)

(Date)

I hereby certify that I personally asked every question of the Owner, and Proposed Insured if other than the Owner, and accurately recorded the answers given and that I witnessed the signature(s) above.

(Signature of Writing Agent)

(Print Name of Writing Agent)

(Agent's Number)

(Agent Phone Number)

**Authorization for Use or Disclosure
Of Protected Health Information**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.
2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.
3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

Print Name and Date of Birth of Proposed Insured

Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Date

Print Name and Date of Birth of Spouse, If Applying

Signature of Spouse, If Applying

Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or Owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER
UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount \$ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West
Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount \$ _____

by _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE
CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do
not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If
Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not
accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a
required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions
are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom
coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the
policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we
deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material
change in your answers on the application since the application date; and (3) you have paid any additional premium and/or
signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be
insured under the policy applied for prior to delivery will not exceed the lesser of: (a) \$250,000, including accidental death
benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF
THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

Term

Question Number	Question Description	Additional questions generated by a yes answer	Drop-down options	Misc. Notes
--	Family Number	none	none	For internal use only Family numbers are variable and will be assigned by the Home Office
--	Application Number	none	none	The application number will appear at the top of each page of the application. This number will differ for each application and will be assigned by the Home Office.
--	Relationship	if "Other" selected, will provide a text box for description	Self Spouse Child Parent Sibling Grandparent Grandchild Business Trust Other	same drop-down options for each party to contract (insured, owner, payor, primary and contingent beneficiaries, successor owner, custodian)
1	Gender	none	Male/Female	
1	Marital Status	none	Single Married Separated Divorced Widowed	
3 and 3a	State	none	List of all 50 states	
3 and 3a	County	none	List of applicable counties based on state selection	
7	Payment Mode	Details field if PAC, Special Billing, or Payroll Deduction selected	Annual, Semi-Annual, Quarterly, PAC (Pre-Authorized Check), Special Billing, Government Allotment, Payroll Deduction	Details will print at question #7a; this question will not appear if there are no remarks
8	Beneficiary	if "unequal shares" selected, display box for percent of proceeds to each named beneficiary if "other" selected, display text box for instructions	Equally or to Survivor(s) Equally Per Stirpes Equally Per Capita Unequally Other	options appear for both primary and contingent beneficiaries
8	Contingent Beneficiary	if "unequal shares" selected, display box for percent of proceeds to each named beneficiary if "other" selected, display text box for instructions	Equally or to Survivor(s) Equally Per Stirpes Equally Per Capita Unequally Other	If none selected, will print "none" on the application.
10	Replacement	Company drop-down*, company name, policy number, face amount, reason for replacement	*Shelter or other; if other, then will provide text box for name of company	info from this question will also populate the replacement form
12	MVR	Details	none	
13	Aviation	none	none	If yes, will produce the Aviation Questionnaire; this has already been approved through the Interstate Compact

				If yes, will produce the Hazardous Sports Questionnaire; this has already been approved through the Interstate Compact
14	Hazardous Sports	none	none	
15	Alcohol/drugs	Details and physician information		
16	Medical history	Details and physician information		